CAMPBELL PHYSICAL THERAPY & SPORTSCARE

DS PHYSICAL THERAPY AND SPORTSCARE

PATIENT INFORMATION			**EMAIL ADDRESS:**_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	**(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)**
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	**(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)**		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:		Ext.:
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Campbell Physical Therapy & SportsCare. I understand that I am financially responsible for any balance. I also authorize Campbell Physical Therapy & SportsCare to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

MEDICAL HEALTH HISTORY

1. Have you had treatment for this/these problems before? ☐ Yes ☐ No

   If yes, where and when were you treated? _____

2. Have you had surgery related to this/these problems? ☐ Yes ☐ No

   If yes, what type of surgery did you have and when was the surgery?

   _____

3. Have you had any injections for your current problem? ☐ Yes ☐ No If yes, location: _____
4. Do you currently have any metal implants ☐ Yes ☐ No
5. Do you have a pacemaker? ☐ Yes ☐ No
6. Do you have any communicable diseases? ☐ Yes ☐ No
7. Are you pregnant? ☐ Yes ☐ No

   If so, how many months? _____

8. List any medications you are currently taking:

   _____

   _____

9. In general, your overall health right now is (check one):

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

DESCRIPTION OF SYMPTOMS:

Date of injury or onset of symptoms: _____

Describe how your injury occurred or when/how your symptoms began:

_____

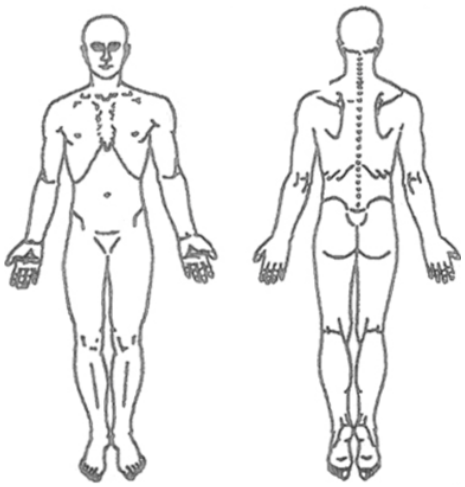
_____

Current complaint:

_____

_____

Please indicate on the diagram where you experience your pain/symptoms:



My pain is increased by: _____

My pain is decreased by: _____

Type of pain: ☐ shooting ☐ burning ☐ aching ☐ sharp ☐ dull ☐ tingling ☐ other: _____

When do you experience your pain/symptoms?

Times/Week ☐ AM/ ☐ PM With activity:

The frequency of your symptoms are (check one):

☐ Constantly (75-100% of the day) ☐ Frequently (51-75% of the day)

☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

During the past 4 weeks the most severe intensity of your symptoms were (check one):

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

DESCRIPTIONS OF FUNCTIONAL LIMITATIONS AND GOALS:

What activities in your daily life are affected the most by your current complaint, including recreational/social activities, functional activities and work around the house?

_____

If you have limitations/restrictions at your job, what are they?

_____

How much has the pain interfered with your work?

What are your goals for the first two weeks? _____

What are your goals at 6-8 weeks?_____

_____ _____

Patient/Patient Representative's Signature Date

CAMPBELL PHYSICAL THERAPY

AGREEMENT TO PAY

I understand and agree that I am responsible and liable for payment of all charges assessed for professional services rendered. I understand insurance claims forms will be submitted to my insurance company as a matter of convenience to me and I am primarily responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Campbell Physical Therapy.

I authorize payment of medical benefits to Campbell Physical Therapy for services rendered. A copy of this authorization can be considered as an original for insurance purposes. I also give consent to receive physical therapy treatments.

Signature_____Date_____

CAMPBELL PHYSICAL THERAPY AND SPORTSCARE
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Campbell Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW OUR OFFICE WILL PROTECT YOUR HEALTH INFORMATION AND YOUR RIGHTS AT A PATIENT.

CAMPBELL PHYSICAL THERAPY'S LEGAL DUTY.
We are required by law to protect the privacy of your personal health information and will only use that information in order to treat you or to assist other health providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information.

DISCLOSURE NOT REQUIRING YOUR AUTHORIZATION. In the following circumstances, we may disclose your health information without your written authorization:

To family members or close friends who are involved in your health
For certain limited research purposes
For purposes of public health and safety
To Government agencies for purposes of their audits, investigations and other oversight activities
When required by court orders, search warrants, subpoenas and as otherwise required by law.

PATIENT'S INDIVIDUAL RIGHTS. As our patient, you have the following rights:

To have access to and/or a copy of your health information
To receive an accounting of certain disclosures we have made of your health information
To request restrictions as to how your health information is used or disclosed
To request that we communicate with you in confidence
To request that we amend your health information
To receive notice of our privacy practices

CONCERNS AND COMPLAINTS. If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer, Chris Ota at 408-866-5567. If you are still concerned after talking with our Privacy Officer, you may file a written complaint with the Department of Health and Human Services.

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Campbell Physical Therapy's Notice of Patient Information Practices. I understand that you may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

_____ _____

PATIENT NAME PATIENT SIGNATURE (Guardian if patient is a minor)

_____

DATE